		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037572

Facility Name: HILLCREST HEALTHCARE CENTER

Address: 777 DRAPER AVE (Number) JOLIET (City) 60432 (Zip Code)

County: WILL

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-3782789

Date of Initial License for Current Owners: 09/15/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHERWIN I. RAY

(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	84	Skilled (SNF)	84	30,660	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,320	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	32		2,739	2,771	8
9	SNF/PED					9
10	ICF	45,238	1,365		46,603	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,270	1,365	2,739	49,374	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.52%

D. How many bed-hold days during this year were paid by Public Aid?
352 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/15/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/15/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 2,739

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	161,964	21,408	14,490	197,862		197,862	942	198,804			1
2	Food Purchase		186,124		186,124	(12,702)	173,422	(919)	172,503			2
3	Housekeeping	133,756	25,780		159,536		159,536		159,536			3
4	Laundry	55,198	15,613	646	71,457		71,457		71,457			4
5	Heat and Other Utilities			105,791	105,791		105,791	417	106,208			5
6	Maintenance	46,731	53,490	48,062	148,283		148,283	7,725	156,008			6
7	Other (specify):*			10,981	10,981		10,981		10,981			7
8	**TOTAL General Services**	397,649	302,415	179,970	880,034	(12,702)	867,332	8,165	875,497			8
	B. Health Care and Programs											
9	Medical Director			25,900	25,900		25,900		25,900			9
10	Nursing and Medical Records	1,365,004	66,912	205,716	1,637,632		1,637,632	(167,709)	1,469,923			10
10a	Therapy		2,401	39,542	41,943		41,943	3,460	45,403			10a
11	Activities	81,622	12,479		94,101		94,101		94,101			11
12	Social Services	252,697		162	252,859		252,859		252,859			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,699,323	81,792	271,320	2,052,435		2,052,435	(164,249)	1,888,186			16
	C. General Administration											
17	Administrative	95,492		180,000	275,492		275,492	(126,783)	148,709			17
18	Directors Fees											18
19	Professional Services			279,975	279,975		279,975	(173,701)	106,274			19
20	Dues, Fees, Subscriptions & Promotions			22,153	22,153		22,153	(4,076)	18,077			20
21	Clerical & General Office Expenses	111,021	11,258	162,553	284,832		284,832	(41,345)	243,487			21
22	Employee Benefits & Payroll Taxes			410,684	410,684	12,702	423,386		423,386			22
23	Inservice Training & Education			2,618	2,618		2,618	1,008	3,626			23
24	Travel and Seminar			235	235		235	404	639			24
25	Other Admin. Staff Transportation			7,225	7,225		7,225	2,847	10,072			25
26	Insurance-Prop.Liab.Malpractice			147,555	147,555		147,555	4,283	151,838			26
27	Other (specify):*			40,000	40,000		40,000	(449)	39,551			27
28	**TOTAL General Administration**	206,513	11,258	1,252,998	1,470,769	12,702	1,483,471	(337,812)	1,145,659			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,303,485	395,465	1,704,288	4,403,238		4,403,238	(493,896)	3,909,342			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER #0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			39,161	39,161		39,161	5,267	44,428			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			71,410	71,410		71,410	33,021	104,431			32
33	Real Estate Taxes			69,441	69,441		69,441		69,441			33
34	Rent-Facility & Grounds			721,972	721,972		721,972	8,484	730,456			34
35	Rent-Equipment & Vehicles			41,858	41,858		41,858	(4,798)	37,060			35
36	Other (specify):*											36
37	TOTAL Ownership			943,842	943,842		943,842	41,974	985,816			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		99,332	29,441	128,773		128,773	(4,007)	124,766			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			91,980	91,980		91,980		91,980			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		99,332	121,421	220,753		220,753	(4,007)	216,746			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,303,485	494,797	2,769,551	5,567,833		5,567,833	(455,929)	5,111,904			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,191)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(919)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(358)	20		17
18	Fines and Penalties	(23,170)	21		18
19	Entertainment				19
20	Contributions	(400)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,000)	27		24
25	Fund Raising, Advertising and Promotional	(5,121)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(681)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(3,496)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (82,336)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(373,593)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (373,593)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (455,929)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

HILLCREST HEALTHCARE CENTER

ID# 0037572

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (3,496)	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,496)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	942	0	0	0	0	0	0	0	0	0	942	1
2	Food Purchase	(919)	0	0	0	0	0	0	0	0	0	0	(919)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	417	0	0	0	0	0	0	0	0	0	417	5
6	Maintenance	(3,496)	11,221	0	0	0	0	0	0	0	0	0	7,725	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,415)	12,580	0	0	0	0	0	0	0	0	0	8,165	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(167,709)	0	0	0	0	0	0	0	0	0	(167,709)	10
10a	Therapy	0	8,842	(5,382)	0	0	0	0	0	0	0	0	3,460	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(158,867)	(5,382)	0	0	0	0	0	0	0	0	(164,249)	16
	C. General Administration													
17	Administrative	0	(126,783)	0	0	0	0	0	0	0	0	0	(126,783)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(173,701)	0	0	0	0	0	0	0	0	0	(173,701)	19
20	Fees, Subscriptions & Promotions	(6,560)	0	2,484	0	0	0	0	0	0	0	0	(4,076)	20
21	Clerical & General Office Expenses	(23,170)	(100,800)	82,625	0	0	0	0	0	0	0	0	(41,345)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,008	0	0	0	0	0	0	0	0	1,008	23
24	Travel and Seminar	0	0	404	0	0	0	0	0	0	0	0	404	24
25	Other Admin. Staff Transportation	0	0	2,847	0	0	0	0	0	0	0	0	2,847	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,283	0	0	0	0	0	0	0	0	4,283	26
27	Other (specify):*	(40,000)	0	39,551	0	0	0	0	0	0	0	0	(449)	27
28	TOTAL General Administration	(69,730)	(401,284)	133,202	0	0	0	0	0	0	0	0	(337,812)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(74,145)	(547,571)	127,820	0	0	0	0	0	0	0	0	(493,896)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(8,191)	0	13,458	0	0	0	0	0	0	0	0	5,267	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	33,021	0	0	0	0	0	0	0	0	33,021	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	8,484	0	0	0	0	0	0	0	0	8,484	34
35	Rent-Equipment & Vehicles	0	0	(4,798)	0	0	0	0	0	0	0	0	(4,798)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,191)	0	50,165	0	0	0	0	0	0	0	0	41,974	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(4,007)	0	0	0	0	0	0	0	0	(4,007)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	(4,007)	0	0	0	0	0	0	0	0	(4,007)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(82,336)	(547,571)	173,978	0	0	0	0	0	0	0	0	(455,929)	45

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					NILES	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 180,000	CAREPLUS MGMT INC		$	$ (180,000)	1
2	V	19	ADMIN. CONSULTANT FEES	168,000	" "			(168,000)	2
3	V	19	DATA PROCESSING FEES	13,200	" "			(13,200)	3
4	V	21	CLERICAL FEES	100,800	" "			(100,800)	4
5	V	1	DIETARY CONSULTANT FEES	7,200	" "			(7,200)	5
6	V	1	DIETARY SALARIES		" "		8,142	8,142	6
7	V	5	ELECTRICITY		" "		417	417	7
8	V	6	REPAIRS		" "		990	990	8
9	V	6	MAINTENANCE SALARIES		" "		10,231	10,231	9
10	V	10	NURSING	200,000	" "		32,291	(167,709)	10
11	V	10a	THERAPY SALARIES		" "		8,842	8,842	11
12	V	17	ADMIN SALARIES		" "		53,217	53,217	12
13	V	19	PROFESSIONAL FEES		" "		7,499	7,499	13
14	Total			$ 669,200			$ 121,629	$ * (547,571)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	DUES/LICENSES/WANT ADS	$	CAREPLUS MGMT INC		$ 2,484	$ 2,484	15
16	V	21	OFFICE SALARIES/EXPENSES		" "		82,625	82,625	16
17	V	23	SEMINARS		" "		1,008	1,008	17
18	V	24	TRAVEL		" "		404	404	18
19	V	25	TRANSPORTATION		" "		2,847	2,847	19
20	V	26	INSURANCE		" "		4,283	4,283	20
21	V	27	EMPLOYEE BENEFITS		" "		39,551	39,551	21
22	V	30	SL DEPRECIATION		" "		13,458	13,458	22
23	V	32	INTEREST		" "		33,021	33,021	23
24	V	34	OFFICE RENT		" "		8,484	8,484	24
25	V	35	EQUIP RENT/AUTO LEASE	12,658	" "		7,860	(4,798)	25
26	V								26
27	V								27
28	V								28
29	V	10a	THERAPY SERVICES	39,541	CAREPLUS REHABILITATIVE SERVICES		34,159	(5,382)	29
30	V	39	ANCILLARY THERAPY	29,440	" "		25,433	(4,007)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 81,639			$ 255,617	$ * 173,978	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCI	34.67	SEE ATTACHED	5.1	8.52	SALARY	15,755	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	34.67	SCHEDULES	5.1	8.52	" "	15,755	17-7	3
4	JOE ZIMMERMAN	CFO	CLERICAL	0.60	" "	5.1	8.52	" "	10,165	21-7	4
5	JANICE CLAFFORD	CONTROLLER	CLERICAL	0.60	" "	5.1	8.52	" "	4,319	21-7	5
6	ROMY MACASAET	RN CONSULT.	NURSING	0.60	" "	5.1	8.52	" "	7,242	10-7	6
7	JAMEE O'BRIEN	REGIONAL DIR.	ADMIN	0.60	" "	5.1	8.52	" "	9,241	17-7	7
8	TAMMY ORR	RN CONSULT.	NURSING	0.60	" "	5.1	8.52	" "	8,258	10-7	8
9	ROSLYN INDICH	BKKP	CLERICAL	2.38	" "	5.1	8.52	" "	4,089	21-7	9
10											10
11											11
12											12
13								TOTAL	$ 74,824		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	459,177	9 FACILITIES	$ 75,722	$	49,374	$ 8,142	1
2	5	ELECTRICITY	" "	579,760	13 FACILITIES	4,894		49,374	417	2
3	6	REPAIRS	" "	579,760	13 FACILITIES	11,630		49,374	990	3
4	6	MAINTENANCE SALARIES	" "	579,760	13 FACILITIES	120,135	120,135	49,374	10,231	4
5	10	NURSING SALARIES	" "	579,760	13 FACILITIES	379,168	379,168	49,374	32,291	5
6	10a	THERAPY	" "	579,760	13 FACILITIES	103,831	100,459	49,374	8,842	6
7	17	ADMIN SALARIES	" "	579,760	13 FACILITIES	624,886		49,374	53,217	7
8	19	PROFESSIONAL FEES	" "	579,760	13 FACILITIES	88,050		49,374	7,499	8
9	20	DUES/LICENSES/WANT ADS	" "	579,760	13 FACILITIES	29,166		49,374	2,484	9
10	21	OFFICE SALARIES/EXPENSES	" "	579,760	13 FACILITIES	970,207	726,859	49,374	82,625	10
11	23	SEMINARS	" "	579,760	13 FACILITIES	11,834		49,374	1,008	11
12	24	TRAVEL	" "	579,760	13 FACILITIES	4,741		49,374	404	12
13	25	TRANSPORTATION	" "	579,760	13 FACILITIES	33,424		49,374	2,847	13
14	26	INSURANCE	" "	579,760	13 FACILITIES	50,288		49,374	4,283	14
15	27	EMPLOYEE BENEFITS	" "	579,760	13 FACILITIES	464,414		49,374	39,551	15
16	30	SL DEPRECIATION	" "	579,760	13 FACILITIES	158,032		49,374	13,458	16
17	32	INTEREST	" "	579,760	13 FACILITIES	387,734		49,374	33,021	17
18	34	OFFICE RENT	" "	579,760	13 FACILITIES	99,626		49,374	8,484	18
19	35	EQUIP RENT/AUTO LEASE	" "	579,760	13 FACILITIES	92,291		49,374	7,860	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,710,073	$ 1,326,621		$ 317,654	25

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC						$	$			$ 33,021	1
2												2
3												3
4	CAREPLUS MGMT - CIB BK		X	CAPL IMPR LOAN FEES	5 YR AMORT	2/23/01	2,250	1,425	1/23/06		450	4
5	CAREPLUS MGMT - CIB BK		X	CAPITAL IMPROVEMENT	$9,478.71	2/23/01	450,000	298,705	1/23/06	PRIME+	28,105	5
	Working Capital											
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND	04/95	1,925,000	1,160,000		PRIME+	39,840	6
7	INSURANCE FINANCING		X	INSUR. FINANCE							3,015	7
8												8
9	TOTAL Facility Related				$9,478.71		$ 2,377,250	$ 1,460,130			$ 104,431	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,377,250	$ 1,460,130			$ 104,431	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 65,050	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 66,911	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,861	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 67,580	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 69,441	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	58,191	8
	1998	58,377	9
	1999	61,241	10
	2000	64,403	11
	2001	66,911	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible] Office of Health Finance at (217) 782-1600.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HILLCREST HEALTHCARE CENTER COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0037572

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-11-101-003-0000	NURSING HOME	$ 66,911.14	$ 66,911.14
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 66,911.14	$ 66,911.14

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,039 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	132,928		$	1
2					2
3	TOTALS	132,928		$	3

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	6,230	198	31.5	198		2,212	9
10	LEASEHOLD IMPROVEMENTS			1992	48,072	1,525	31.5	1,526	1	16,023	10
11	LEASEHOLD IMPROVEMENTS			1993	33,291	981	31.5	1,057	76	10,041	11
12	LEASEHOLD IMPROVEMENTS			1994	10,172	261	39	261		2,186	12
13	ROOF REPAIR			1995	5,221	134	39	134		977	13
14	CONDENSING UNITS			1996	3,924	101	39	101		669	14
15	CEILING TILES			1996	1,334	34	39	34		220	15
16	ROOF REPAIR			1996	8,079	207	39	207		1,320	16
17	DOORS			1997	1,078	28	39	28		155	17
18	WINDOWS & ROOF VENTILATOR			1997	3,572	92	39	92		464	18
19	WINDOWS			1998	12,100	309	39	310	1	1,427	19
20	ROOF REPAIRS/DOORS/ELEC. REPAIRS/LOT LIGHTS			1998	23,693	607	39	607		2,768	20
21	WALLCOVER/RAILS/NURSE STNS/WINDOW TREATMENTS			1998	155,436	3,985	39	3,985		17,837	21
22	WINDOWS/DECORATING/CEILING TILE/ROOF REPAIR			1999	70,751	1,814	39	1,814		6,394	22
23	WINDOWS/FLOORING/DOOR			2000	12,169	442	27.5	442		1,166	23
24	CARPETING			2000	2,088	365	10	209	(156)	522	24
25	DOORS/ELEVATOR REPAIRS/SECURITY SYSTEM UPGRADE			2001	42,268	1,536	27.5	1,537	1	2,642	25
26	FENCE			2001	10,361	691	15	691		1,036	26
27	ROOF REPAIRS/CEILING TILE/FIRE DAMPERS/LIGHTING			2001	43,148	1,568	27.5	1,569	1	1,872	27
28	ROOF REPAIRS/HEAT/AC REPAIRS			2002	17,346	183	27.5	183		183	28
29	FENCE			2002	4,573	152	15	152		152	29
30											30
31											31
32											32
33											33
34	RELATED PARTY ALLOCATION - CAREPLUS MGMT					100		100			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 514,906	$ 15,313		$ 15,237	$ (76)	$ 70,266	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 183,361	$ 19,054	$ 15,343	$ (3,711)	8-15 YRS	$ 72,013	71
72	Current Year Purchases	11,123	4,894	490	(4,404)	10-15 YRS	490	72
73	Fully Depreciated Assets	35,500					35,500	73
74	** RELATED PARTY - ALLOCATED SL DEPN: CAREPLUS MGMT, 13,358		13,358	13,358				74
75	TOTALS	$ 229,984	$ 37,306	$ 29,191	$ (8,115)		$ 108,003	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 744,890	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 52,619	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 44,428	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (8,191)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 178,269	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: DRAPER PLAZA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		168	9/15/91	$ 721,972	15		3
4	Additions							4
5								5
6								6
7	TOTAL		168		$ 721,972 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 9/15/91
Ending 9/15/16

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2003	$
13.	12/31/2004	$
14.	12/31/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 30,961 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ACTIVITY/HSKP/	FACILITY VAN	$	$ 2,700	17
18	MAINT	FORD VAN	683.10	8,197	18
19					19
20					20
21	TOTAL		$ 683.10	$ 10,897	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 19,923	$		$ 19,923	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			243			243	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			9,275			9,275	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				94,338		94,338	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2					2,142		2,142	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					2,852		2,852	13
14	TOTAL			$		$ 29,441	$ 99,332		$ 128,773	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER **#** 0037572 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,329	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,766,781		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	106,192		6
7	Other Prepaid Expenses	10,941		7
8	Accounts Receivable (owners or related parties)	25,000		8
9	Other(specify): R.E.TAX ESCROW	57,607		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,967,850	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	514,906		15
16	Equipment, at Historical Cost	229,983		16
17	Accumulated Depreciation (book methods)	(253,336)		17
18	Deferred Charges	1,425		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEP	1,366		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 494,344	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,462,194	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 641,542	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,160,000		29
30	Accrued Salaries Payable	94,859		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,062		31
32	Accrued Real Estate Taxes(Sch.IX-B)	67,580		32
33	Accrued Interest Payable	11,547		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,983,590	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	298,705		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 298,705	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,282,295	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 179,899	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,462,194	$	48

***(See instructions.)**

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 156,654	1
2	Restatements (describe):		2
3	**POST-CLOSING ALLOWANCE FOR BAD DEBTS**	(50,000)	3
4	**ROUNDING**	1	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 106,655	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	73,244	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 73,244	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 179,899	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,655,162	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,655,162	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,655,162	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	880,034	31
32	Health Care	2,052,435	32
33	General Administration	1,470,769	33
	B. Capital Expense		
34	Ownership	943,842	34
	C. Ancillary Expense		
35	Special Cost Centers	128,773	35
36	Provider Participation Fee	91,980	36
	D. Other Expenses (specify):		
37	OUT OF PERIOD EXPENSES	13,285	37
38	LEGAL SETTLEMENT	800	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,581,918	40
41	**Income before Income Taxes (line 30 minus line 40)****	73,244	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 73,244	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,007	4,338	$ 117,974	$ 27.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,095	13,972	313,091	22.41	3
4	Licensed Practical Nurses	19,449	20,704	396,272	19.14	4
5	Nurse Aides & Orderlies	45,255	50,105	426,381	8.51	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,846	3,030	48,900	16.14	9
10	Activity Assistants	4,922	5,258	32,722	6.22	10
11	Social Service Workers	17,871	19,446	252,697	12.99	11
12	Dietician					12
13	Food Service Supervisor	1,813	1,984	30,334	15.29	13
14	Head Cook	5,960	6,634	52,790	7.96	14
15	Cook Helpers/Assistants	12,522	13,478	78,840	5.85	15
16	Dishwashers					16
17	Maintenance Workers	3,803	4,079	46,731	11.46	17
18	Housekeepers	19,567	21,225	133,756	6.30	18
19	Laundry	6,552	7,493	55,198	7.37	19
20	Administrator	1,979	2,109	75,964	36.02	20
21	Assistant Administrator	885	942	19,528	20.73	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,784	6,205	111,021	17.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,689	1,786	17,643	9.88	31
32	Other Health Ca MENTAL HEALT	4,241	4,516	93,643	20.74	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,240	187,304	$ 2,303,485 *	$ 12.30	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,200	1-3	35
36	Medical Director	O	25,900	9-3	36
37	Medical Records Consultant	N	52,112	10-3	37
38	Nurse Consultant	T	50,000	10-3	38
39	Pharmacist Consultant	H	504	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	162	12-3	45
46	Other(specify)	S			46
47	PSYCHIATRIC/MENTAL HEALTH		100,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 246,678		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JEFFREY KALKOWSKI	ADMIN	0	$ 75,964
JEFFREY BAKER	ASST ADMIN	0	19,528
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 95,492

B. Administrative - Other

Description		Amount
CAREPLUS MGMT	MANAGEMENT FEES	$ 180,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 180,000

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS MGMT	DATA PROC	$ 13,200
CAREPLUS MGMT	ADMIN CONSULT	168,000
AMERICAN DATA	DATA PROC	2,506
KBKB	ACCT	29,550
WINSTON & STRAWN	LEGAL	50,886
MEYER MAGENCE	LEGAL	4,135
SACHNOFF WEAVER	LEGAL	1,000
KIPNIS KAHN	LEGAL	200
PERSONNEL PLANNERS	UNEMPL CONSULT	1,695
RICHARD PEELO	M/C COST REPORT	3,750
ECONOCARE	PURCHASING CONSULT	3,528
NATIONAL DATACARE	DATA PROC	1,525
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 279,975

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,739
Unemployment Compensation Insurance	18,467
FICA Taxes	173,256
Employee Health Insurance	151,510
Employee Meals	12,702
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,340
EMPLOYEE PHYSICAL EXAMS	14
PENSION/PROFIT SHARING PLANS	17,358
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 423,386

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	4,994
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	5,802
TRUST/FRANCHISE/CONTRIB/ETC	758
LICENSES & PERMITS	(4)
DUES & SUBSCRIPTIONS	10,203
MGMT CO ALLOCATION	2,484
TRUST/FRANCHISE/CONTRIB/ETC	(758)
Less: Public Relations Expense	(0)
Non-allowable advertising	(5,121)
Yellow page advertising	(681)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,077

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	235
MGMT CO ALLOCATION	404
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 639

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	2001	$ 7,075	3	$	$	$ 1,180	$ 2,358	$ 2,358	$ 1,179	$	$	$
2	PAINT/DECORATING	2002	7,025	3				1,171	2,342	2,342	1,170		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 14,100		$	$	$ 1,180	$ 3,529	$ 4,700	$ 3,521	$ 1,170	$	$

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $8,770**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **516** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **91,980**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **12,702** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: HILLCREST HEALTHCARE CENTER #0037572 **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,200	
	REPAIRS & MAINTENANCE		7,290	
			0	14,490
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		646	
			0	646
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		9,413	
	ELECTRICITY		59,407	
	WATER		36,416	
	CABLE TV - LOBBY		555	
			0	105,791
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,059	
	PAINTING & DECORATING		7,025	
	BUILDING REPAIRS		5,356	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,041	
	ELEVATOR MAINTENANCE & REPAIR		12,597	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,148	
	FIRE SERVICE		5,836	
			0	
			0	
			0	48,062
7	**OTHER**			
	SCAVENGER		10,981	
	SECURITY SERVICE		0	10,981
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	25,900	25,900

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		100	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	52,112	
	PHARMACY CONSULTANT	XVIII B 39-2	504	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC/MENTAL HEALTH	XVIII B 47-2	100,000	
	RN CONSULTANT	XVIII B 38-2	50,000	
	DENTAL SERVICES		3,000	
			0	205,716
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		8,600	
	SPEECH THERAPY SERVICES		1,053	
	OCCUPATIONAL THERAPY SERVICES		5,184	
	THERAPY CONTRACT SERVICES		13,905	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	39,542
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	162	
			0	162
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number HILLCREST HEALTHCARE CENTER **#0037572** **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	180,000	180,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	17,231	
	ADMINISTRATIVE CONSULTANTS	XIX C	168,000	
	PROFESSIONAL FEES	XIX C	94,744	
			0	279,975
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	5,121	
	EMPLOYEE WANT ADS	XIX F	4,994	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	10,203	
	LICENSES & PERMITS	XIX F	396	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	681	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	358	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	400	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	22,153
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,536	
	EQUIPMENT REPAIR & MAINTENANCE		6,840	
	OUTSIDE CLERICAL SERVICES		100,800	
	PENALTIES / OVERDRAFT CHARGES	VI 18	23,170	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		593	
	TELEPHONE		28,411	
	MESSENGER SERVICE		1,203	
			0	162,553

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	173,256	
	UNEMPLOYMENT COMPENSATION	XIX D	18,467	
	WORKERS COMPENSATION INSURANC	XIX D	47,739	
	HOSPITALIZATION INSURANCE	XIX D	151,510	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,340	
	EMPLOYEE PHYSICAL EXAMS	XIX D	14	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	17,358	
	CHICAGO HEAD TAX	XIX D	0	410,684
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,618	2,618
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	235	
			0	
			0	235
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		7,225	7,225
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		147,555	147,555
27	**OTHER**			
	BAD DEBTS	VI 24	40,000	
			0	40,000

GRAND TOTAL COLUMN 3 OTHER 1,704,288

HILLCREST HEALTHCARE CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	186,124
LESS SALES TAX	(919)
NET FOOD	185,205
TOTAL PATIENT CENSUS	49,374
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	148122
ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	10950

PATIENT MEALS	148122
ADD EMPLOYEE MEALS	10950
TOTAL MEALS/YEAR	159072
NET FOOD	185205
DIVIDE TOTAL MEALS/YEAR	159072
COST PER MEAL	1.16
TIME EMPLOYEE MEALS	10950
EMPLOYEE MEAL RECLASSIFICATION	12702

HILLCREST HEALTHCARE CENTER
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S										5,563,417	
		NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT		2,052,435	410,684	424,591	71,457	383,986	1,060,085	91,980	943,842		2,303,485
ADJUSTMENTS:											
	EQUIPMENT RENTAL/AUTO LEASE	4,854		8,352			28,652		(41,858)		
	CABLE TV			(555)			555				
	CONTRACT NURSING										
	INTEREST INCOME							0			
	NET VENDING COMMISSIONS										
	EMPLOYEE PHYSICAL EXAMS		(14)				14				
	INSURANCE - EXECUTIVE LIFE		0				0				
	MANAGEMENT FEES						(180,000)		180,000		
	O2 INCOME										
	BAD DEBTS						(40,000)	40,000			
	DISCOUNTS LOST							0			
	ANCILLARIES	128,773							0		
	SETTLEMENT INTEREST						800				
	RECLASSED SALARIES	(111,286)	0	0	0	0	111,286	0	0		
	PROFIT SHARING	0	0	0	0	0	0	0	0		
	PRIOR EXPENSES	0	0	0	0	0	0	(78,460)	0		
	BENEFITS REBILLED	0	0	0	0	0	0	0	0		
	RENT/INTEREST	0	0	0	0	0	0	0	0		
	NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS		2,074,776	410,670	432,388	71,457	383,986	981,392	53,520	1,081,984	5,490,173	2,303,485
PER FINANCIAL STATEMENTS		2,074,776	410,670	432,388	71,457	383,986	981,392	(53,520)	1,081,984	73,244	2,303,485
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS										73,244	

HILLCREST HEALTHCARE CENTER - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		61,320			61,320			0	61488		
CENSUS DAYS		49,374			44,843			4,531	47496		
OCCUPANCY %		80.52%			73.13%				77.24%		
SALARIES											
TOTAL General Services	8-1	397,649	7.78%	8.05	390147	7.69%	8.70	7,502	376697	8.33%	7.93
Social Services	12-1	252,697	4.94%	5.12	206326	4.07%	4.60	46,371	127094	2.81%	2.68
TOTAL Health Care and Programs	16-1	1,699,323	33.24%	34.42	1643362	32.41%	36.65	55,961	1483510	32.80%	31.23
Clerical & General Office Expenses	21-1	111,021	2.17%	2.25	151968	3.00%	3.39	(40,947)	90109	1.99%	1.90
TOTAL General Administration	28-1	206,513	4.04%	4.18	352611	6.95%	7.86	(146,098)	235440	5.21%	4.96
TOTAL Operation Expense	29-1	2,303,485	45.06%	46.65	2386120	47.05%	53.21	(82,635)	2095647	46.34%	44.12
ADJUSTED TOTALS											
Food	2-8	172,503	3.37%	3.49	166179	3.28%	3.71	6,324	158300	3.50%	3.33
Heat and Other Utilities	5-8	106,208	2.08%	2.15	109619	2.16%	2.44	(3,411)	114863	2.54%	2.42
Maintenance	6-8	156,008	3.05%	3.16	165711	3.27%	3.70	(9,703)	133762	2.96%	2.82
TOTAL General Services	8-8	875,497	17.13%	17.73	869360	17.14%	19.39	6,137	820834	18.15%	17.28
Administrative	17-8	148,709	2.91%	3.01	306290	6.04%	6.83	(157,581)	252693	5.59%	5.32
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	106,274	2.08%	2.15	107175	2.11%	2.39	(901)	45378	1.00%	0.96
Fees, Subscriptions, Promotions	20-8	18,077	0.35%	0.37	17684	0.35%	0.39	393	22057	0.49%	0.46
License Fee-IDPA	Pg21	400	0.01%	0.01	200	0.00%	0.00	200	0	0.00%	0.00
License Fee-Other	Pg21	(4)	0.00%	(0.00)	834	0.02%	0.02	(838)	1799	0.04%	0.04
Clerical & General Office Expenses	21-8	243,487	4.76%	4.93	274553	5.41%	6.12	(31,066)	197626	4.37%	4.16
Employee Benefits & Payroll Taxes	22-8	423,386	8.28%	8.58	391977	7.73%	8.74	31,409	344672	7.62%	7.26
Payroll Taxes	Pg21	191,723	3.75%	3.88	199287	3.93%	4.44	(7,564)	177466	3.92%	3.74
W/C Insurance	Pg21	47,739	0.93%	0.97	46432	0.92%	1.04	1,307	47565	1.05%	1.00
Health Insurance	Pg21	151,510	2.96%	3.07	102742	2.03%	2.29	48,768	102382	2.26%	2.16
Inservice Training & Education	23-8	3,626	0.07%	0.07	3566	0.07%	0.08	60	6901	0.15%	0.15
Travel and Seminar	24-8	639	0.01%	0.01	642	0.01%	0.01	(3)	173	0.00%	0.00
Other Admin. Staff Transportation	25-8	10,072	0.20%	0.20	11025	0.22%	0.25	(953)	6745	0.15%	0.14
Insurance-Prop.Liab.Malpractice	26-8	151,838	2.97%	3.08	136423	2.69%	3.04	15,415	85210	1.88%	1.79
Other (specify):*	27-8	39,551	0.77%	0.80	34325	0.68%	0.77	5,226	24021	0.53%	0.51
TOTAL General Administration	28-8	1,145,659	22.41%	23.20	1283660	25.31%	28.63	(138,001)	985476	21.79%	20.75
TOTAL Operation Expense	29-8	3,909,342	76.48%	79.18	3932980	77.56%	87.71	(23,638)	3416276	75.54%	71.93
Real Estate Taxes	33-3	69,441	1.36%	1.41	67603	1.33%	1.51	1,838	64131	1.42%	1.35
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	5,111,904	100.00%	**103.53**	5071137	100.00%	**113.09**	40,767	4522674	100.00%	**95.22**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1708816.4	33.43%	**34.61**	1883058.7	37.13%	**41.99**	(174,242)	1562316.4	34.54%	**32.89**

HILLCREST HEALTHCARE CENTER - DIAGNOSTICS - 12/31/2002

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 3529 from Page 22 and -7025 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-33021 MGMT CO 33021
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-13458 MGMT CO 13458
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 = Page 14 Line 7-4.
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.